

**Houston Area HIV Services Ryan White Planning Council**

**2012 Houston Area Comprehensive HIV Services Plan  
LEADERSHIP TEAM**

2:00 p.m., Monday, September 26, 2011

Meeting Location: 2223 W. Loop South, Room #416

**AGENDA**

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| I. Call to Order  | Sherifat Akorede, Tam Kiehnhoff, and Cristan Williams, Co-Chairs |
| A. Welcome  |  |
| B. Moment of Reflection   |  |
| C. Adoption of the Agenda   |  |
| D. Introductions & Ice-Breaker  |  |
| E. Review, Edit, and Adoption of Membership Requirements, Voting Rules, and Quorum          | Tori Williams, Manager<br>Office of Support                      |
|   |  |
| II. Orientation to the 2012 Comprehensive Planning Process                                  | Jennifer Hadayia, Health Planner, Office of Support              |
| A. Refresher of the 2012 Comprehensive Plan Structure                                       |  |
| B. Review of Milestones Timeline; and Ensuring “Synergy”                                    |  |
| C. Discussion of Leadership Team Expectations and Process                                   | Tori Williams, Manager<br>Office of Support                      |
|   |  |
| III. Workgroup Updates  |  |
| A. Evaluation   | Nicholas Sloop, Steven Vargas<br>Pam Green, Bruce Turner         |
| B. Coordination of Effort   |  |
| C. Gaps in Care and Out-of-Care   | Amber David, David Garner  |
| D. Prevention and Early Identification  | Amy Leonard, Ken Malone  |
| E. Special Populations  | David Watson   |
|   |  |
| IV. Envisioning the Ideal System, Part I  | Jennifer Hadayia, Health Planner, Office of Support              |
| A. Review of Key Data Trends on HIV/AIDS and the Needs of People Living with HIV/AIDS       |  |
| B. Review of 2009 Comprehensive Plan Mission, Vision, Values, Guiding Principles, and Goals |  |
| C. Review of HIV/AIDS Services National Priorities  |  |
| D. <i>Round-Robin</i> : “Your Vision of an Ideal HIV System”                                |  |
| E. Discussion of Data Collection/Informational Needs Going Forward                          |  |

V. Next Steps

- A. Review of Meeting Schedule
- B. What to Expect at the Next Meeting
- C. Feedback on Process to Date
- D. Questions or Concerns

Sherifat Akorede, Tam  
Kiehnhoff, and Cristan  
Williams, Co-Chairs

VI. Announcements

VII. Adjourn

**Houston Area HIV Services Ryan White Planning Council**  
**Office of Support**  
2223 West Loop South, Suite 240, Houston, Texas 77027  
713 572-3724 telephone; 713 572-3740 fax  
[www.rwpchouston.org](http://www.rwpchouston.org)

**2012 Houston Area Comprehensive HIV Services Plan**  
**MEMBERSHIP ROSTER**  
**Last Updated 19-Sep-11**

**LEADERSHIP TEAM**

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*First Meeting: September 26, 2011, 2:00 PM Room 416*

**Co-Chairs:**

- Sherifat Akorede, representing Ryan White Planning Council (Ryan White Program Part A)
- Tam Kiehnhoff, representing Ryan White Program Part B
- Cristan Williams, representing City of Houston HIV Prevention Community Planning Group

**Members:**

1. Gayle Alstot, MD, Manager of Operations, The Center for AIDS Information and Advocacy
2. Roberto A. Andrade, MD, Thomas Street Health Center; Assistant Professor-Infectious Diseases, Baylor College of Medicine-Houston; and Medical Director, AETC-Houston
3. Ray Andrews, Houston Crackdown
4. Melody Barr, Administration Manager, City of Houston Housing and Community Development, Housing Opportunities for People with AIDS (HOPWA)
5. Jeffrey Benavides, Latino Task Force, City of Houston; and Harris County Hospital District
6. David Benson, Aid to County Commissioner El Franco Lee
7. Francis Bueno, Montrose Counseling Center, representing Serving the Incarcerated and Recently Released (SIRR)
8. Ron Cookston, Gateway to Care
9. Amber David, Disease Investigation Specialist, Houston Department of Health and Human Services; and *Gaps in Care and Out of Care Workgroup Co-Chair*
10. Roy Delesbore, Texas Department of State Health Services, Region 6
11. David Garner, Houston Ryan White Planning Council; and *Gaps in Care and Out of Care Workgroup Co-Chair*
12. Rodney Goodie, St. Hope Foundation
13. Pam Green, RN, Memorial Hermann Hospital System; and *Coordination of Effort Workgroup Co-Chair*
14. Lisa Marie Hayes, MBA, Managing Local Ombudsman, Access & Assistance Coordinator, Area Agency on Aging, Houston-Galveston Area Council
15. Charles Henley, Manager, Ryan White Grant Administration, Harris County Public Health & Environmental Services
16. Monica James, Gateway to Care
17. Florida Kweekkeh, Youth Task Force, Houston Department of Health and Human Services
18. Anna Langford, Planner, The Houston Regional HIV/AIDS Resource Group
19. Michael Lawson, External Member-Ryan White Planning Council
20. Amy Leonard, Legacy Community Health Services; and *Prevention and Early Identification Workgroup Co-Chair*

21. Sam Lopez, Medical Lead Care Coordinator, Harris County Jail, representing Serving the Incarcerated and Recently Released (SIRR)
22. Nike Lukan, Chair, African American State of Emergency Task Force; and AIDS Foundation Houston
23. Ken Malone, Harris County Hospital District; and *Prevention and Early Identification Workgroup Co-Chair*
24. Aundrea Matthews, PhD Candidate in Religious Studies, Rice University
25. Mary Jo May, Chair, Board of Directors, Partners for Community Health
26. Scot More, Coalition for the Homeless of Houston/Harris County
27. Nicholas Sloop, Houston Department of Health and Human Services, Bureau of HIV/STD and Viral Hepatitis Prevention; and *Evaluation Workgroup Co-Chair*
28. Cecilia Smith-Ross, Chair, Houston Ryan White Planning Council; and Founder, Living Without Limits Living Large Inc.
29. Bruce Turner, M-PACT; and *Coordination of Effort Workgroup Co-Chair*
30. Steven Vargas, HEI Case Manager, MAP Program, Association for the Advancement of Mexican Americans (AAMA); and *Evaluation Workgroup Co-Chair*
31. David Watson, Jail Team and Special Populations Coordinator, Houston Department of Health and Human Services; and *Special Populations Workgroup Co-Chair*

## **WORKGROUPS:**

### **COORDINATION OF EFFORT WORKGROUP**

*First Meeting: September 26, 2011, 1:00 PM Room 240*

#### Co-Chairs:

- Bruce Turner, M-PACT
- Pam Green, Memorial Hermann Hospital System

#### Members:

1. Sherifat Akorede, Houston Department of Health and Human Services
2. Gayle Alstot, MD, The Center for AIDS Information and Advocacy
3. Roberto A. Andrade, MD, Thomas Street Health Center; Assistant Professor-Infectious Diseases, Baylor College of Medicine-Houston; and Medical Director, AETC-Houston
4. Ray Andrews, Houston Crackdown
5. Melody Barr, Housing Opportunities for People with AIDS (HOPWA)
6. Ron Cookston, Gateway to Care
7. Lisa Marie Hayes, MBA, Managing Local Ombudsman, Access & Assistance Coordinator, Area Agency on Aging, Houston-Galveston Area Council
8. Monica James, Gateway to Care
9. Tam Kiehnhoff, Triangle AIDS Network
10. Carin Martin, Ryan White Grant Administration
11. Aundrea Matthews, PhD Candidate, Rice University
12. Ryan Rushing, Walgreens

## **EVALUATION WORKGROUP**

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*Next Meeting: October 4, 2011, 1:00 p.m., Room 532*

### Co-Chairs

- Steven Vargas, Association for the Advancement of Mexican-Americans (AAMA)
- Nicholas Sloop, Houston Department of Health and Human Services

### Members:

1. Ben Barnett, MD, Associate Professor of Medicine, University of Texas Health Science Center
2. Camden Hallmark, Houston Department of Health and Human Services
3. Judy Hung, Ryan White Grant Administration
4. Kevin Jackson, Community Member
5. Sam Lopez, Harris County Jail
6. Ken Malone, Harris County Hospital District
7. Aundrea Matthews, PhD Candidate in Religious Studies, Rice University
8. Osaro Mgbere, Houston Department of Health and Human Services
9. Erik Soliz, Senior Health Planner, Houston Department of Health & Human Services, Bureau of HIV/STD & Viral Hepatitis Prevention
10. Bruce Turner, M-PACT
11. Lena Williams, Baylor College of Medicine, Project LEAP

## **GAPS IN CARE AND OUT-OF-CARE WORKGROUP**

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*Next Meeting: October 21, 2011, 12:00 p.m., Room 240*

### Co-Chairs:

- David Garner, Houston Ryan White Planning Council
- Amber David, Houston Department of Health and Human Services

### Members:

1. Jeff Benavides, Latino Task Force, City of Houston; and Harris County Hospital District
2. Linda Hollins, Texas Department of State Health Services
3. Januari Leo, Legacy Community Health Services
4. Ken Malone, Harris County Hospital District
5. Charolyn Mosley, Goodwill – Project Hope
6. Robert Smith, External Member-Ryan White Planning Council
7. Cecilia Smith-Ross, Chair, Houston Ryan White Planning Council; and Founder, Living Without Limits Living Large Inc.
8. Barbara Walker, Legacy Community Health Services
9. Cristan Williams, Transgender Foundation of America

## **PREVENTION AND EARLY IDENTIFICATION WORKGROUP**

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*Next Meeting: October 12, 2011, 2:00 p.m., Room 240*

### Co-Chairs:

- Ken Malone, Harris County Hospital District
- Amy Leonard, Legacy Community Health Services

### Members:

1. Sherifat Akorede, Houston Department of Health and Human Services
2. Roy Delesbore, Texas Department of State Health Services, Region 6
3. Pam Green, RN, Memorial Hermann Hospital System
4. Brenda Harrison, Planned Parenthood Gulf Coast
5. Kevin Jackson, Community Member
10. Michael Lawson, External Member-Ryan White Planning Council
11. Januari Leo, Legacy Community Health Services
12. Nike Lukan, Chair, African American State of Emergency Task Force; and AIDS Foundation Houston
13. Susan Rokes, Planned Parenthood
14. Roslyn Rose, Pink Rose-Saving Our Community Kids...Seniors (SOCKS)
15. Robert Smith, External Member-Ryan White Planning Council
16. Erik Soliz, M-PACT, Houston Department of Health & Human Services
17. Amana Turner, Change Happens!
18. Ray E. Watts, DD, ThD, MEd, MCC, Urban AIDS Ministry
19. Simone Woodage, Sex Education for Parents of Teenagers and Preteens (SEFPOT)

## **SPECIAL POPULATIONS WORKGROUP**

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*Next Meeting: October 19, 2011, 10:00 a.m. Room 240*

### Co-Chairs:

- David Watson, Jail Team and Special Populations Coordinator, Houston Department of Health and Human Services
- TBD

### Members:

1. Ray Andrews, Houston Crackdown
2. Kristina Arcscott, Healthcare for the Homeless
3. Michael Bass, AIDS Foundation Houston
4. Jeff Benavides, Latino Task Force, City of Houston; and Harris County Hospital District
5. (tent) Antoinette Boone, Housing Opportunities for People with AIDS (HOPWA)
6. Francis Bueno, Montrose Counseling Center, representing Serving the Incarcerated and Recently Released (SIRR)
7. Morénike Giwa, Positive Playdates
8. (tent) Rose Haggerty, Houston Independent School District
9. Kevin Jackson, Community Member
10. Florida Kweekeh, Youth Task Force, City of Houston
11. Sam Lopez, Harris County Jail, representing Serving the Incarcerated and Recently Released (SIRR)

12. Scot More, Coalition for the Homeless of Houston/Harris County
13. Cristan Williams, Transgender Foundation of America
14. Maxine Young, AIDS Foundation Houston

The following guidelines are from the 2011 Needs Assessment Group and are proposed for use by the 2012 Comprehensive HIV Services Plan Leadership Team

## Membership Requirements, Voting Rules and Quorum for the

### Needs Assessment Group (NAG)

Quorum for the Needs Assessment Group (NAG) is defined as:

- 1 representative from 3 of the 4 workgroups (see below\*).
- 7 additional committee members (including a NAG co-chair).
- Of these 10, at least 2 must be PWAs (not including a chair).
- Of these 10, there must be one Part A Planning Council member and a volunteer or staff member from the CPG.

Membership of the Needs Assessment Group (NAG) is defined as follows:

- Must be a member of at least one of the workgroups.
- No voting at a member's first meeting.
- Each agency gets one vote.
- No more than 2 unexcused absences.

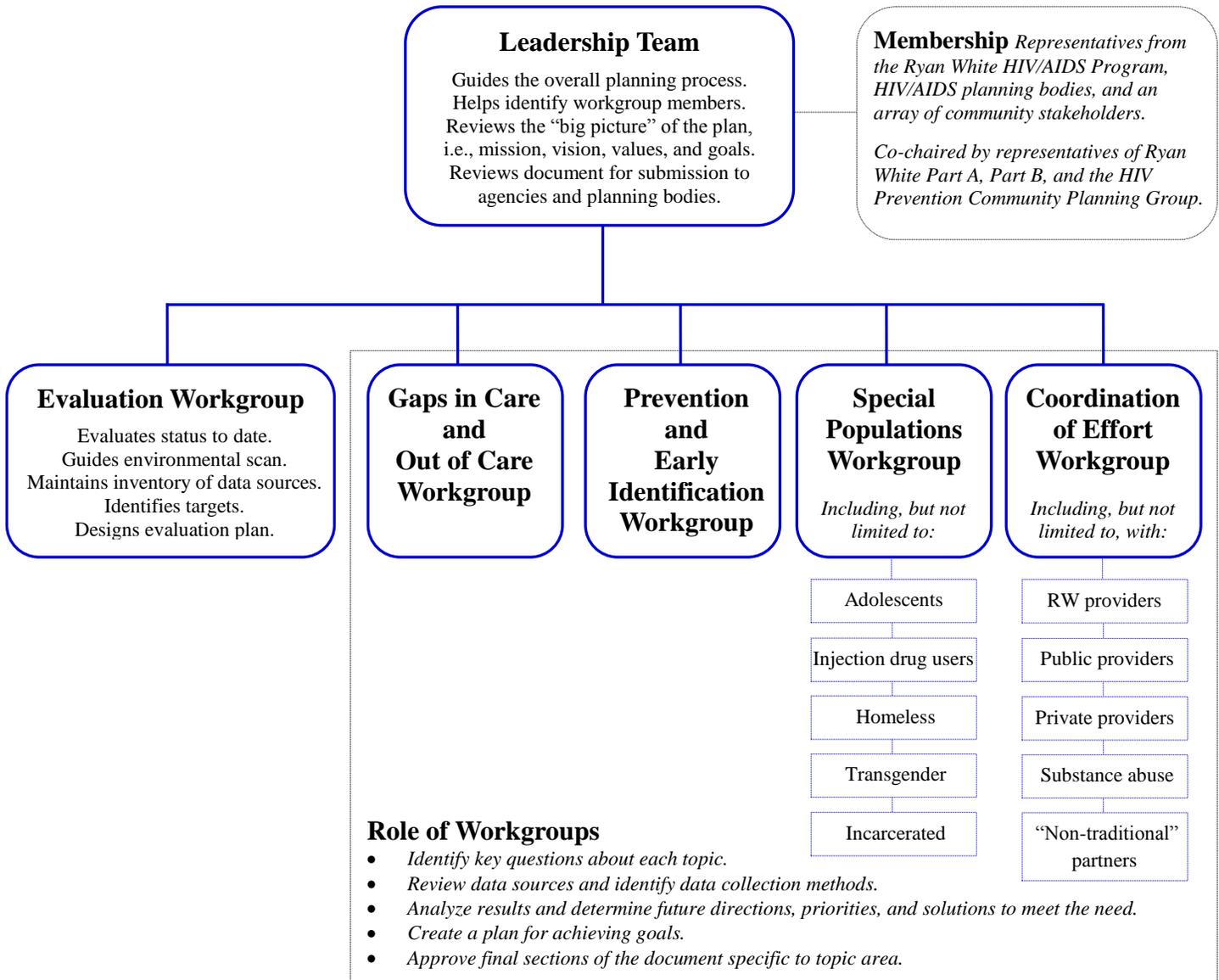
*Members must email Diane Beck (diane.beck@hctx.net) or call the Office of Support (713-572-3724) at least one day in advance, except in an emergency. If a member does not email or call in, they are unexcused.*

\*The 2012 Comprehensive HIV Services Plan Workgroups are:

- Evaluation
- Coordination of Effort
- Gaps in Care and Out-of-Care
- Prevention and Early Identification
- Special Populations

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**2012 Houston Area Comprehensive HIV Services Plan**  
**ORGANIZATIONAL STRUCTURE**



**Houston Area HIV Services Ryan White Planning Council**  
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**2012 Houston Area Comprehensive HIV Services Plan**  
**MILESTONES TIMELINE**

<b>Date<sup>1</sup></b>	<b>Task</b>
August 22, 2011	Adopt process for 2012 comprehensive planning
September 2, 2011	Confirm Leadership Team, Workgroup members, and Co-Chairs
September 6, 2011	Workgroup meetings begin
September 26, 2011	Leadership Team meetings begin
September 26, 2011	Exploration questions and data sources complete from Workgroups
October 4, 2011	2009 Comp Plan Evaluation process complete with recommendations
October 24, 2011	Data collection complete for Workgroups
November 28, 2011	Logic modeling complete from Workgroups
November 28, 2011	Mission, vision, values, etc. review complete from Leadership Team
December 30, 2011	Draft of Sections II-III complete; reviewed with Workgroups per schedule
January 23, 2012	Approve Sections II-III with Leadership Team
February 7, 2012	Draft of Section IV complete and approved with Evaluation Workgroup
February 7, 2012	Draft of Section I complete
February 2012	Gather input on Sections II-III from community members and stakeholders
February 27, 2012	Sections II-III revised per community input
February 27, 2012	Full draft of plan complete; grantee review; LT review
March 22, 2012	CPG Meeting: Approve 2012 Comp Plan (April 26 <sup>th</sup> Back-Up)
March 26, 2012	LT Meeting: Approve 2012 Comp Plan (April 23 <sup>rd</sup> Back-Up)
March 26, 2012	CHP Meeting: Approve 2012 Comp Plan (April 23 <sup>rd</sup> Back-Up)
April 5, 2012	Steering Committee: Approve 2012 Comp Plan (May 3 <sup>rd</sup> Back-Up)
April 12, 2012	RWPC Meeting: Approve 2012 Comp Plan (May 10 <sup>th</sup> Back-Up)
May 7, 2012	Concurrence letters due
May 21, 2012	2012 Comprehensive Plan due to HRSA

<sup>1</sup> Dates subject to change; document last updated 09-06-11

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**2012 Houston Area Comprehensive HIV Services Plan**  
**ROLE DESCRIPTION**

Role: **Leadership Team**  
Timeframe: **September 2011 – May 2012**

### **Background**

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Jurisdictions funded by the Health Resources and Services Administration (HRSA) to provide HIV-related services (a.k.a., the Ryan White HIV/AIDS Program) must have a *Comprehensive HIV Services Plan* in place for their area. The current Houston Area plan expires December 2011, and an updated three-year plan must be submitted to HRSA by May 2012. To achieve this goal, Houston's two HIV planning bodies, the Ryan White HIV/AIDS Program grantees, and other community stakeholders will come together through a series of ad hoc working groups to design solutions and plans for various topics related to HIV care and services, including addressing gaps in care, the needs of certain priority populations, coordination of effort across programs, and the application of new national initiatives.

The development of a Comprehensive HIV Services Plan creates a unique opportunity for all individuals and groups concerned about HIV/AIDS in the Houston area. It allows for service providers, stakeholders, consumers of HIV services, and concerned community members to help determine HIV service priorities as well as help steer the activities of the region's Ryan White HIV/AIDS Programs and planning bodies. Once complete, the plan will serve as guidance for Houston area decision-makers, funders, and service providers as they design and provide HIV services in the future.

### **Role of the Leadership Team**

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The Leadership Team is the "steering committee" of the comprehensive planning process. Its primary role is to advise and guide the process by providing ongoing feedback and direction on structure, timeline, and outputs. The Leadership Team also helps identify working group membership and reviews the comprehensive plan at all stages. In addition, the Leadership Team provides the "big picture" perspective on HIV care and services in the Houston area and, as such, reviews and reaffirms the mission, vision, values, overarching principles, and systems-level HIV care goals.

Leadership Team membership will represent an array of agencies, including the Ryan White HIV/AIDS Programs, Administrative Agents, Planning Bodies, and key community stakeholders, institutions, groups, and coalitions. Consumers of Ryan White services will also serve as Leadership Team members. Additionally, the co-chairs of each focus area working group will serve on the Leadership Team to provide linkages to working group activities.

The Leadership Team will be jointly chaired by a representative from each of the two Houston area Administrative Agents (Ryan White Parts A and B) and from HIV prevention community planning.

## **Expectations of Leadership Team Members**

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- Attend monthly Leadership Team meetings.
- Help identify individuals to serve on focus area Workgroups (e.g., Evaluation, Gaps in Care/Out of Care, Prevention/Early Identification, Special Populations, and Coordination of Effort).
- Review and provide feedback on work produced by the Workgroups.
- Provide direction on overall planning issues and concerns.
- Review Mission, Vision, Values, Guiding Principles, and Goals.
- Participate in the design of the community vetting and public input process for the plan (e.g., community meetings, etc.).
- Review and provide feedback on draft sections of the plan.
- Facilitate review of and concurrence with the plan by agency leadership prior to submission.
- Participate in additional planning Workgroups, if time allows.

In addition to the above activities, Leadership Team Co-Chairs will:

- Facilitate monthly meetings in accordance with Robert's Rules of Order and Open Meeting Law.
- As needed, serve as spokespeople for the Leadership Team and the comprehensive planning process.
- Assist in the selection and appointment of Co-Chairs for the five Workgroups.
- As needed, fill gaps in the assignments of other Leadership Team members.

# 2011 Integrated Epidemiological Profile for HIV/AIDS Prevention and Care Planning

## Houston HSDA & EMA

*DRAFT: March 2011*

***For more information contact:***

Jen H. Kim, Health Planner  
Office of Support for the  
Houston Ryan White Planning Council  
713 572-3724



# EXECUTIVE SUMMARY

## SOCIODEMOGRAPHIC DATA

The Houston-Area EMA is comprised of six counties and the HSDA includes these six plus four others. The population center of the region is Harris County, with over 80% of the EMA population and nearly 79% of the HSDA population. Outside Harris County most counties are rural with three EMA counties and two HSDA counties reporting 60% or more rural residents. The populations of both the EMA and HSDA are projected to grow at a faster rate than Texas overall, 18% compared to 16% for the state. The fastest growing counties are those adjacent to Harris, and include Montgomery (29%), Fort Bend (27%) and Waller (26%).

In Harris and Fort Bend Counties, minorities make up the “majority” of residents. White/Anglo are the majority in all other counties.

- ⌘ Hispanics/Latinos make up 30% of the EMA’s and HSDA’s populations and 32% of the state’s.
  - Twenty percent of EMA and HSDA residents were born outside the U. S. This compares to 14% in the state of Texas. These foreign born residents most frequently come from North, Central and South America.
  - Mexico is the most frequent place of foreign birth, accounting for about half of those born outside the U. S.
  - Approximately one-third of EMA and HSDA residents are “linguistically isolated,” meaning they speak English less than “very well.” The predominant second language is Spanish.
- ⌘ Non-Hispanic Blacks/African-Americans are 17% of the people in the region compared to 11% in Texas.
- ⌘ Asians are 5% of the local population and less than 3% of those living in the state. Fort Bend County has the largest percentage of Asian residents.

Both the EMA and the HSDA have higher median incomes than the state overall. Within the EMA, the median income is nearly \$47,000 per year and within the HSDA, the median income is \$42,000. This compares to just under \$40,000 for Texas. Fort Bend (\$64,000 per year) and Montgomery (\$50,000 per year) have the two highest median incomes as well as the highest levels of educational attainment.

The EMA and HSDA have lower poverty rates than Texas overall, but the poverty rate is higher than found throughout the U. S. The region has approximately 14% poverty; the state has 15.4%, and the U. S. has only 12.4%.

As a state, Texas ranked first in the U. S. in 1998 according to percent of population uninsured (24.5%) and second in size of the uninsured population (4,880,000). In the

10-county area, counties ranged between one-fifth and one-quarter of their populations uninsured. In addition, all of the HSDA counties have full or partial designation as medically underserved areas (MUA). Six entire counties are designated as medically underserved.

- ✚ Liberty County, the county with the highest unemployment in the region, has the highest mortality rate of the 10 HSDA Counties, ranking thirteenth in the state of Texas. They have the highest infant mortality rate in the state, and are in the top 15 for cancer, lower respiratory diseases and accidents.
- ✚ Fort Bend has the lowest death rate of the ten HSDA counties, ranking 197 in the state.

### **SURVEILLANCE DATA**

At the end of 2007, a total of 19,393 people were living with HIV/AIDS in the Houston HSDA, more than half (11,232; 58%) of whom had an AIDS diagnosis. There were 914 newly reported HIV cases, and 933 new AIDS cases for the year.

There are people living with HIV/AIDS in all 10 HSDA counties with 94% of cases reported in Harris County.

Males have an HIV prevalence rate that is two times higher than that of females, and an AIDS prevalence rate that is three times higher. However, there are indications of an increase in new HIV infections among women, who represent 31% of living HIV cases in both the EMA and HSDA, but only 23% of living AIDS cases.

Blacks/African-Americans have the highest rate of new HIV and new AIDS infections – almost six times higher than the infection rate for Hispanics/Latinos and more than seven times higher than that of Whites/Anglos. More than half of new diagnoses for both HIV and AIDS are among Blacks/African-Americans (55%), followed by Hispanics/Latinos (24%) and Whites/Anglos (19%). Black/African-American women constitute the largest percentage (73%) of newly diagnosed women of childbearing age. Hispanic men are infected with HIV at a rate of more than 4 times that of Hispanic/Latina women, and 4 times higher for AIDS. There is also an increase in new HIV and AIDS diagnoses among Hispanic MSMs.

The 25 to 44 age group has the highest rates of new HIV and AIDS infections. The HIV infection rate among youth aged 13 to 24 is over two times higher than their rate for AIDS diagnoses. Black/African-American youth in particular are disproportionately affected by HIV/AIDS.

Male to male contact accounts for 42% of all HIV/AIDS cases in the HSDA, followed by heterosexual contact (24%) and intravenous drug use. Unreported risk among those with HIV accounts for approximately 28% of new HIV diagnoses and 17% of AIDS diagnoses.

## **SERVICE UTILIZATION**

Service utilization, other than primary care, is evaluated using the CPCDMS system, which includes Ryan White Part A and B data. Utilization patterns on primary medical care, case management, dental care, substance abuse treatment, mental health therapy and counseling and ADAP services are compared to surveillance data on those living with HIV disease. *Please note that the most current epidemic data for this report is 2007 data from DSHS HARS, while service utilization data from the CPCDMS is from 2008.*

### **PRIMARY MEDICAL CARE:**

- ⓧ White PLWHA are under-represented in primary medical care services.
- ⓧ Primary care is accessed proportionately by PLWHA of all ages and both genders.

### **CASE MANAGEMENT:**

- ⓧ White PLWHA is under-represented in case management, while Black PLWHA account for a higher proportion of clients than the regional epidemic.
- ⓧ Overall, case management utilization is proportional by age and gender.

### **DENTAL CARE:**

- ⓧ There is a disproportionately higher access of dental care by older adults.
- ⓧ Black/African-American PLWHA are under-utilizing dental services, while Hispanics are slightly overrepresented among those who use dental services.

### **SUBSTANCE ABUSE TREATMENT:**

- ⓧ Treatment is under-utilized by Hispanics and disproportionately used more by White PLWHA.
- ⓧ Adults aged 25-44 tended to utilize this service more, while there is under-representation in substance abuse clients for older adults aged 55+.

### **MENTAL HEALTH THERAPY AND COUNSELING:**

- ⓧ White PLWHA account for a higher proportion among those utilizing services when compared to their proportion among the epidemic. Noteworthy is that White males account for the largest proportion of mental health clients.
- ⓧ Black PLWHA are under-represented among those utilizing mental health services.
- ⓧ From 2006 to 2008, there appears to be a trend towards more rural clients while service utilization decreased for adults aged 25 to 34 and increased for older adults aged 55+.

**ADAP:**

- ⓧ Hispanic PLWHA over-utilized ADAP services while White PLWHA appear to be under-represented among ADAP clients when compared to their distribution within the regional epidemic.
- ⓧ Usage by gender and age group appear to be proportional when compared to the regional epidemic.

**UNMET NEEDS ESTIMATES**

Identifying people who are aware of their HIV positive status and who are not receiving HIV medical care is a Health Resources Services Administration (HRSA) mandate, and a central focus of regional and national planning. One of the first steps in designing effective interventions is identifying the number and characteristics of those who are out-of-care, known as the “unmet need.”

Unmet need for medical care is defined following the HRSA definition such that a PLWHA is said to have unmet need for medical care if there is no evidence of either a CD4 count, a viral load (VL) test or antiretroviral therapy (ART) during the 12 months of interest. If there is evidence of one of these three things being present, the person is considered to have their medical needs met.

As of December 31, 2007, the number of PLWA was 11,358 and the number of PLWH (non-AIDS, aware) was 7,891. The total number of people living with HIV and AIDS in the Houston EMA was 19,249.

The number of PLWA in care was 7,766, or 68% of the total number of PLWA in the Houston EMA as of December 31, 2007. The number of PLWH (non-AIDS, aware) in care was 4,303 (55%) among all PLWH in the EMA. The total number of PLWHA who received HIV primary medical services as of the end of 2007 was 12,069 (63%).

Using the inputs for care patterns obtained, the Houston EMA estimates that 3,592 (32%) of the diagnosed PLWA were not receiving HIV primary medical care. For PLWH, 3,588 (45%) were found to be out-of-care. After combining the two groups, the total number of PLWHA who had unmet need in the Houston EMA through the end of 2007 was 7,180 (37%) among all PLWHA. Please note that estimates provided by TDSHS indicate that the Houston EMA has the highest level of unmet need (37% by their estimates) when compared to other EMAs in the state (Fort Worth 31%, San Antonio 30%, Dallas 26% and Austin 23%).

# **2011 Houston Area HIV/AIDS Needs Assessment**

*A COLLABORATIVE PROJECT OF THE:*

**Houston Ryan White Planning Council**

**Houston Regional HIV/AIDS Resource Group**

**Harris County Hospital District**

**Harris County Public Health and Environmental Services  
Ryan White Grant Administration**

**Houston Department of Health and Human Services (HDHHS)**

**City of Houston HIV Prevention  
Community Planning Group (HHPCPG)**

**Housing Opportunities for Persons with AIDS (HOPWA)**

**Coalition for the Homeless of Houston/Harris County**



# 2011 Houston Area HIV/AIDS Needs Assessment

## Executive Summary

### Introduction

A needs assessment produces detailed information about service usage for a defined population and, as a result, is an essential tool for planning for service-delivery in a community. Every three years, a needs assessment of People Living with HIV/AIDS (PLWHA) in the Houston Area is conducted. Its purpose is to gather information on the health and human services that PLWHA in Houston use, their potential barriers to services, and their continued areas of service need. The information gathered is then used by Houston Area HIV/AIDS service providers and planning bodies as they make programmatic decisions on how to best meet the needs of PLWHA.

For the 2011 Houston Area HIV/AIDS Needs Assessment, 924 PLWHA were surveyed from the local Health Services Designation Area (HSDA), a 10-county area that includes the counties of Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. Survey participants were queried on 11 topics related to HIV services, including service usage history for both medical and social services, barriers to seeking or receiving services, and co-occurring health conditions. Their responses were analyzed in light of demographic characteristics, risk factors for HIV/AIDS, and other conditions that can impact access to care, such as being homeless, living in a rural setting, or being recently released from the criminal justice system. Focus groups with HIV service providers and an analysis of current HIV/AIDS epidemiological data were also conducted.

Of PLWHA who participated in the needs assessment survey, almost all (95%) resided in Harris County. The majority were also male (67%), Black/African-American (55%), heterosexual (52%), and had at least a high school diploma or GED (80%). Their average age was 45. Nine percent (9%) of participants were homeless, 19% were recently released from jail or prison, 24% had no annual income, and 35% were unemployed. The average length of time being HIV positive was 11 years, and the majority (93%) was currently *in care* for HIV/AIDS.

### The Scope: HIV/AIDS in the Houston Area

According to the Centers for Disease Control and Prevention, the Houston Area ranks 13<sup>th</sup> in the nation among all metropolitan statistical areas for rate of new HIV cases (2009). In Texas, Harris County ranks 11<sup>th</sup> among all counties for rate of new HIV, but is 1<sup>st</sup> in the state for the *number* of new people diagnosed with HIV/AIDS as well as for the number of PLWHA (2010).

In 2008 (the last year for which verified local data is available), 1,903 new cases of HIV/AIDS were diagnosed in the Houston Area HSDA, and, of which, over half (54%) were new HIV cases (not yet progressed to AIDS). Men and Blacks/African-Americans had the highest rates of new infection. Men Who Have Sex with Men (MSM) and heterosexual contact accounted for the majority of attributed risk among new cases. Overall, the rate of new HIV cases in the Houston Area is on the rise, while the rate of new AIDS cases is declining.

Also in 2008, there were 20,190 PLWHA in the Houston Area HSDA, and, of which, over half (58%) had progressed to AIDS. Trends among PLWHA mirror those among the newly-diagnosed: men and Blacks/African-Americans had the highest rates, and MSM and heterosexual contact accounted for the majority of attributed risk. However, there were some notable differences: statistical comparison suggests a possible increase in PLWHA who are women and youth (aged 13 to 24 years).

The mortality rate associated with HIV/AIDS in the Houston Area HSDA has remained relatively stable. Most recent estimates place the rate of HIV/AIDS death at 10.5 per 100,000 cases, or 540 deaths annually (2007). Rates of death among PLWHA were highest among men, Blacks/African-Americans, MSM, and heterosexual contact.

The vast majority of and highest rates for new HIV/AIDS cases as well as PLWHA were in Harris County.

### **The Response: HIV/AIDS Programs in the Houston Area**

In the Houston Area, there are four main federally-funded programs dedicated to HIV/AIDS services; together, they represent the continuum of HIV service needs, from diagnosis to end-stage disease:

- The Ryan White HIV/AIDS Program Part A provides federally-defined core HIV/AIDS services in the Houston Eligible Metropolitan Area (EMA). Examples of core services include primary outpatient medical care, case management, and medication assistance. According to recent estimates, 8,262 PLWHA receive services through Part A. Part A is administered by the Harris County Public Health and Environmental Services, Ryan White Grant Administration.
- The Ryan White HIV/AIDS Program Part B provides core HIV/AIDS medical services throughout the HSDA, which includes the EMA. Part B also includes the AIDS Drug Assistance Program (ADAP) and services specifically targeted to the region's rural counties. According to recent estimates, approximately 4,700 PLWHA receive Part B services. Part B is administered by the Texas Department of State Health Services and, locally, by the Houston Regional HIV/AIDS Resource Group.
- The Houston Area HIV Prevention Program provides HIV testing, diagnosis, and linkage to care. They also provide community-wide risk-reduction education and school-based prevention programs. All new cases of HIV/AIDS are reported to the Program as part of mandated disease surveillance and are followed by partner identification/notification efforts. Prevention programs are operated by the Houston Department of Health and Human Services.
- Housing Opportunities for People with AIDS (HOPWA) provides grants to community organizations to help meet the housing needs of low-income PLWHA. Examples of services include rent, mortgage and utility assistance, permanency planning, and community-based residences for PLWHA. HOPWA is administered by the City of Houston Housing and Community Development.

### **The Need: Key Findings about PLWHA's Experiences with HIV/AIDS Services in the Houston Area**

Diagnosis. The 2011 Houston Area HIV/AIDS Needs Assessment aimed to gather information about the entire continuum of HIV services,

which begins at the time of HIV/AIDS diagnosis. Therefore, needs assessment participants were asked about their experience with HIV testing. Overall, “feeling sick” was the most commonly cited reason for seeking an HIV test (25% of respondents), followed by having sex with someone with HIV (19%), testing as part of a routine check-up (19%), and engaging in risky behavior (18%). The most commonly reported location for the HIV test was a public or community clinic (40%), followed by jail/prison (16%). Less than half (48%) said they received information about HIV medical services at the time of their diagnosis, and 19% stated they received no information at all.

First Medical Visit. Needs assessment participants were also asked about the time between their HIV/AIDS diagnosis and their first HIV medical visit. Half (50%) reported seeing a doctor for HIV within 1 month of diagnosis, while 14% waited more than 12 months, and 2% said they had never seen a doctor for HIV. PLWHA who more often reported waiting longer than 12 months to see a doctor for HIV were those with a history of being out-of-care (35% of respondents) or who were still out-of-care (21%) as well as White MSM (19%). The most commonly-cited reason for delaying care was fear (42%), followed by denial (35%) and not feeling sick (34%). As with testing, the most commonly-reported location for the first HIV medical visit was a public or community clinic (54%).

Core Medical Services. There are nine types of services defined as “core services” for PLWHA available through the Houston Area Ryan White HIV/AIDS Programs. Needs assessment participants were asked about their experience seeking each core service. Some participants stated that they did not need the service, but, of those that did, services overall were reportedly “very east to get.” The top three accessible and non-accessible core services were ranked as follows:

*Top Three “Very Easy to Get” Core Services In the Houston Area*

1. Medical Services
2. HIV Medications
3. Case Management

*Top Three Core Services That PLWHA “Had Some Difficulty Getting” In the Houston Area*

1. Dentist Visits
2. HIV Medications
3. Case management

Though certain core services ranked at the top of both lists, certain subgroups of PLWHA reported divergent experiences. In general, PLWHA who were not in regular HIV care or who were homeless had difficulty accessing services that others perceived as “easy to get.”

When assessment participants reported having “some difficulty” accessing a service, they were also asked to identify why, using a list of potential barriers. The three most commonly reported barriers to accessing core services were as follows:

*Top Three Barriers to Core HIV Services in the Houston Area*

1. Difficulty making or keeping appointments
2. Long wait times
3. Problems with paperwork

In addition, the majority of participants (63%) reported having a case manager or a specific person at a clinic, hospital, or community organization who is responsible for helping them access HIV services.

HIV Medications. A majority of needs assessment participants (78%) reported being on HIV medications at the time of the survey. Hispanics reported HIV medication usage the most while those that were homeless reported it the least. Overall, the most commonly-cited reason for not taking HIV medications was a T-cell count being too high. About one-quarter (26%) of participants reported stopping their HIV medications at some point in time due to side effects. Fifteen percent (15%) reported difficulty paying for medications.

Supportive Services. In addition to the nine core medical services for PLWHA referenced above, there are 14 services designated as “supportive services” available through the Houston Area Ryan White HIV/AIDS Programs. Needs assessment participants were asked to rank up to five of the 14 “supportive services” as the most useful or important. The top three supportive services were as follows:

*Top Three Most Useful/Important Supportive Services for PLWHA in the Houston Area*

1. Emergency Financial Assistance (EFA), or short-term payments for transportation, food, utilities, or medication
2. Food bank services for food, meals, or nutritional supplements
3. Transportation services to access primary medical care or psychosocial support

Though ranked first in importance for PLWHA, Emergency Financial Assistance was cited as the most difficult-to-access of the supportive services. The top three most difficult-to-access supportive services were as follows:

*Top Three Supportive HIV Services That PLWHA “Had Some Difficulty Getting” In the Houston Area*

1. Emergency Financial Assistance (EFA), or short-term payments for transportation, food, utilities, or medication
2. Food bank services for food, meals, or nutritional supplements
3. Rental assistance and/or shelter vouchers, or short-term assistance to support temporary and/or transitional housing to access medical care

When assessment participants reported having “some difficulty” accessing a supportive service, they were also asked to identify why,

using a list of potential barriers. The three most commonly reported barriers to accessing supportive services were as follows:

*Top Three Barriers to Supportive HIV Services in the Houston Area*

1. Not knowing where to get services
2. Not knowing how to get services
3. Was told they were not eligible for the service

Participants were also asked about sources for social support. The most commonly-cited source was family (35% of respondents), followed by other PLWHA (34%) and doctors, nurses, or agency staff (33%).

Co-Occurring Conditions. Needs assessment participants were also asked about the presence of certain other health conditions that could impact their ability to seek HIV care. One quarter (25%) of participants reported Hepatitis C co-infection, 11% reported a history of active TB, and 31% reported taking high blood pressure medication. In addition, a majority of participants (63%) reported having at least one mental health condition during the previous month, with “serious anxiety/tension” reported most often (52%). Participants were also asked about drug and alcohol use. Overall, about one-third (36%) showed an indication of alcohol abuse, 25% reported using marijuana, 21% reported using cocaine, and 5% reported using amphetamines.

Characteristics of People Who Are Out-Of-Care. Though the Houston Area Ryan White HIV/AIDS Programs serve a large proportion of PLWHA, there are still some PLWHA who are not receiving care. Each year, the programs estimate the number of diagnosed PLWHA who are out-of-care using a federal formula and definition and the best available data. This number is commonly referred to as the “unmet need estimate.” The current Houston Area unmet need estimate is 39% (or 8,101) of diagnosed PLWHA.

In the 2011 Houston Area HIV/AIDS Needs Assessment, 7% (or 66) participants were out-of-care per federal definitions. Those who fell into this category tended to be male, 45 years of age or older, Black/African-American, and heterosexual. Some notable findings about the out-of-care subgroup are as follows:

- The out-of-care were least likely to have received information about HIV medical services at the time of diagnosis. They were also more likely to delay entry into care for more than 12 months. The most common reason for not being in care was that they “felt fine.”
- Those who were out-of-care were more likely to report not having a case manager or to be unsure if they had a case manager.
- Half of those who were out-of-care (50%) reported having no source of social support compared to 19% of all participants.
- Those who were out-of-care were more likely to report emergency assistance (financial, rental assistance, employment) as an important supportive service. They also more frequently reported not knowing where or how to get supportive services as a barrier.

Overall, about one quarter of all needs assessment participants reported stopping their HIV care for one year or more at some point in their history. The most common reason for falling out of care was drug use (50%) followed by losing stable housing (37%) and not wanting to take HIV medications (36%).

**A Note on Data and Data Sources**

Data produced by the 2011 Houston Area HIV/AIDS Needs Assessment are unique because they reflect the first-hand perspectives of PLWHA in the Houston Area. However, the results were not corroborated with the service-utilization patterns of participants. Therefore, they cannot be used as empirical evidence of actual services sought or received. In addition, needs assessment data reflect only those PLWHA who self-selected to participate in the survey process. According to current estimates, the needs assessment sample is approximately 4% of diagnosed PLWHA in the Houston Area. As a result, it is impossible to ascertain if the results are representative of the Houston Area PLWHA population as a whole. With these caveats in mind, however, the 2011 Houston Area HIV/AIDS Needs Assessment is the most current repository of primary data on the HIV services experiences of PLWHA in the Houston Area. Its results can be used to describe PLWHA’s experiences with HIV services and to draw conclusions about ways to potentially increase service access.

The following sources for data were used in this report: Office of the Texas Comptroller, Texas Department of State Health Services, Texas Workforce Commission, U.S. Census Bureau, and the Michael E. DeBakey VA Medical Center.



**The 2009  
Comprehensive HIV Services Plan  
for the Houston Area**

*Through December 31, 2011*

*Effective January 1, 2009*

### ***Mission Statement***

We, the Houston Comprehensive Planning Committee, have come together to update the Comprehensive HIV Services Plan for the Houston EMA/HSDA guided by the following mission:

*We will provide a plan that will be inclusive of the entire continuum of care to improve the quality of life for those infected with and/or affected by HIV/AIDS in the Houston EMA/HSDA by taking a leadership role in the planning and assessment of HIV resources, resulting in the delivery of prevention and care services that are accessible, efficient and culturally affirming until the end of the epidemic is realized.*

### ***Vision Statement***

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for communities affected by HIV and AIDS.

### ***Shared Values***

The following Shared Values outline the GUIDING PRINCIPLES that planners, service providers, consumers and community leaders agree will guide the development and delivery of HIV Services within the geographic area. The guiding principles are informed by the Health Resources and Services Administration's (HRSA) focus on uninsured, underserved and special needs populations, as defined by the following goals:

- Goal 1: Improve Access to Health Care**
- Goal 2: Improve Health Outcomes**
- Goal 3: Improve the Quality of Health Care**
- Goal 4: Eliminate Health Disparities**
- Goal 5: Improve the Public Health and Health Care Systems**
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies**
- Goal 7: Achieve Excellence in Management Practices**

## **Section II**

# **WHERE DO WE NEED TO GO?**

## **CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES**

### **A Shared Vision**

From 2009 to 2011, the community will continue to work together to improve and expand a coordinated system of HIV/AIDS prevention and care in order to improve the quality of life for infected and affected communities. The realization of this vision is informed by the Houston area Continuum of Care.

### **Operational Definition of Continuum of Care**

The ideal continuum of care represents a comprehensive range of services needed by individuals and families at-risk infected and affected by HIV/AIDS. The Houston Area Continuum of Care model describes an ideal system of care that bridges prevention services with care and treatment, and responds to dynamic community needs in a holistic, coordinated, and timely manner.

The Continuum of Care model is a framework for decision-making, and can be used to inform and guide planning bodies, providers, community leaders and consumers in setting priorities and allocating funds for HIV/AIDS services. The Continuum can also guide the Houston area HIV community toward the following objectives:

1. Reduce redundancy of administrative burden and services in the system while ensuring adequate access to those who live in distant areas.
2. Provide adequate input of services through multiple points of access. Think of this as designing a ticketing facility. For HIV and AIDS services, we need not only direct outlets (testing), but adequate links to emergency rooms, drug treatment, STD clinics, and acute care facilities.
3. Facilitate services while not overburdening the staff and capacity of the system.
4. Ensure continuity of services so that consumers find that they are able to move around the system and will not be stuck at any one station.

### **Elements of the Continuum of Care**

The Houston area Continuum of Care takes into account several factors: 1) the mission and vision statements of the various planning bodies; 2) the goals and objectives of the planning bodies; 3) the services available in the delivery system; 4) the linkages necessary to ensure efficiency and effectiveness; and 5) the coordinating mechanisms that can be utilized to ensure effective linkages are established and maintained.

The Continuum of Care is characterized by a range of elements that inform the development and delivery of services in the Houston area. These elements include:

- Identifying and addressing needs of unserved/underserved populations
- Including prevention and care services
- Providing services in an efficient and effective manner
- Providing services in a seamless manner as a person moves among the different levels of care
- Providing high quality and culturally appropriate services
- Advocating for PLWHA service needs
- Encouraging cooperation in the coordination/delivery of services
- Assuring that the community in need is aware of available prevention and care resources
- Promoting the dissemination of information to all constituencies
- Identifying needs, gaps and barriers
- Planning capacity to meet needs
- Improving the quality of life
- Assuring that the system is free of discrimination based on race, color, creed, gender, religion, sexual orientation, disability, or age
- Assuring that PLWHA, the general public, and providers are included in the process

The Houston area Continuum of Care encourages service linkages as the mechanism for creating a seamless system of services that enables clients to easily navigate within different levels of care. The Continuum model illustrates how services can be linked among the wide range of service providers in Houston.

**Table 9: Continuum of Care Tracks**

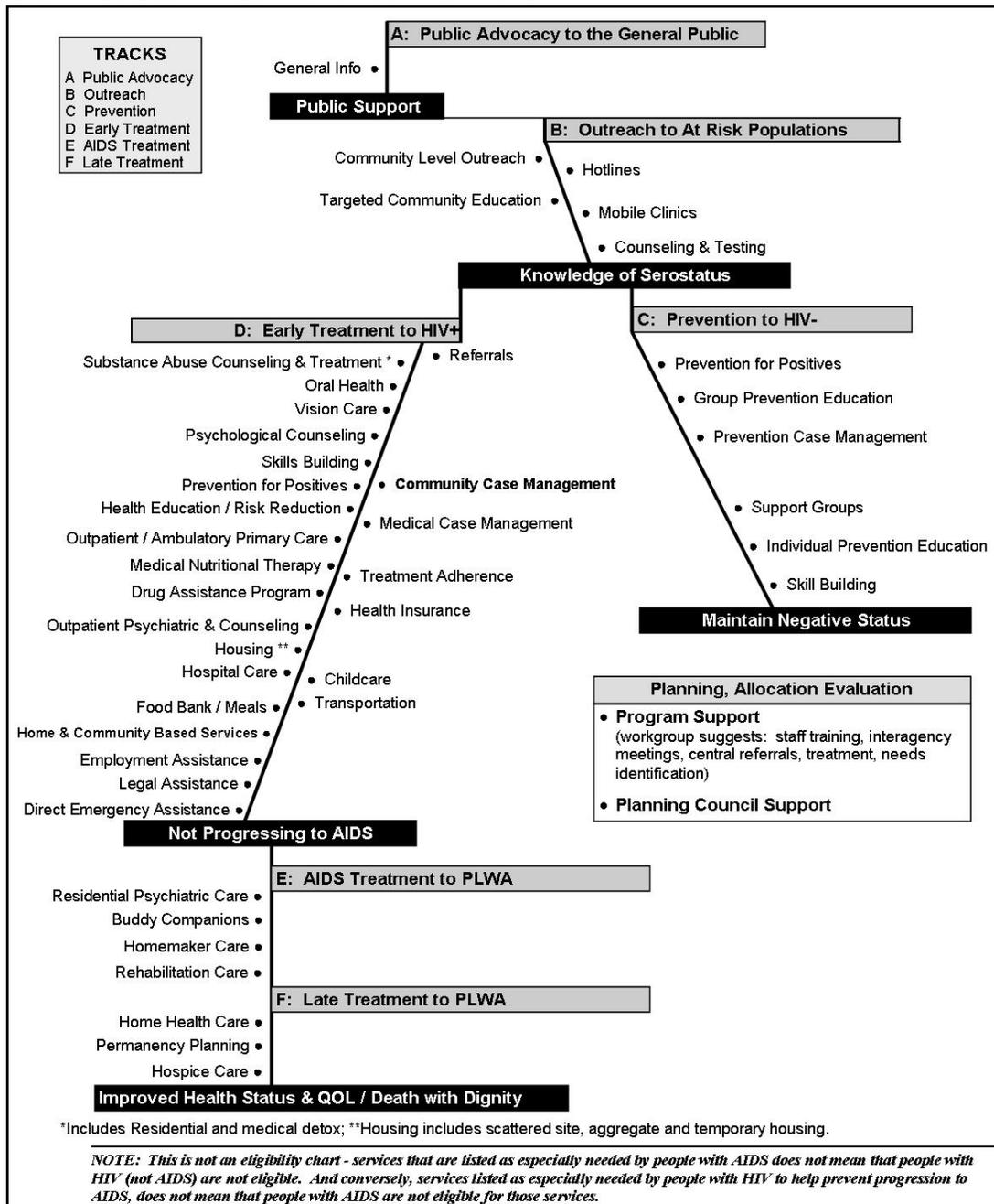
<b>TRACK</b>	<b>START</b>	<b>DESTINATION</b>
A. Public Advocacy to the General Public	No awareness of AIDS	Support for HIV/AIDS services
B. Outreach to at Risk Populations	No awareness of serostatus	Awareness of serostatus
C. Prevention to HIV-	Aware of negative status	Maintenance of negative status
D. Early Treatment to HIV+	Awareness of infection	No progression to AIDS
E. AIDS Treatment to PLWA	AIDS diagnosis	Improved health status and quality of life or death with dignity

The Houston Area Continuum of Care is shown on the following page (Figure 5). The Houston area Continuum of Care is characterized by three main features. First, it has several tracks, each of which is defined by its outcomes. Second, consumers can enter the system at any point on the track. Third, each track runs both ways – consumers can travel up or down each track.

Five attributes can be applied to the Continuum. Referred to as the “5 A’s”, the delivery system is designed to be:

- Available to meet the needs of the PLWHA and their caregivers
- Accessible to all populations infected or affected by HIV/AIDS
- Affordable to all populations infected or affected by HIV/AIDS
- Appropriate for different cultural and socio-economic populations and care needs
- Accountable to the funders and clients for providing contracted services at high quality

Figure 5: Houston Area Continuum of Care



### **Operational Definition of Core Medical Services**

Core Medical Services refer to those services deemed by the Ryan White HIV/AIDS Treatment Modernization Act as most necessary to ensure good medical outcomes for people with HIV / AIDS. The Core Medical Services are defined as:

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;
- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Congress wants to ensure that Ryan White Federal funds are used to pay for essential medical care; thus, areas receiving Ryan White funds under Parts A, B, and C must spend at least 75% of funds on core medical services.

The remaining 25% of funds may be spent on support services. Support services are defined as services that improve access to the core medical services, and directly contribute to achieving positive clinical outcomes for persons with HIV/AIDS. Support services are defined as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

### **A Shared Set of Values**

The Houston area HIV/AIDS community shares a set of values that guide the development and delivery of HIV Services within the geographic area. These values, as informed by HRSA guidelines, address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities; establish and support an HIV care continuum; coordinate resources among other Federal and local programs; and address the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system.

## **Guiding Principles**

The guiding principles for the Houston Area HIV/AIDS Comprehensive Plan are informed by the Ryan White reauthorization principles which are intended to strengthen federal HIV treatment programs. The reauthorization principles include a focus on primary care and treatment, efforts to increase flexibility to target resources and ensuring accountability using sound fiscal management and tools to evaluate program effectiveness

As such, the guiding principles used by the Houston HIV/AIDS community are as follows:

1. Better serve the underserved in response to the HIV epidemic's growing and widespread impact among minority and hard-to-reach populations.
2. Ensure access to effective HIV/AIDS prevention and care services to make a difference in the lives of people infected and affected by HIV and AIDS.
3. Adapt to changes in the health care delivery system and the role of the Ryan White Treatment Modernization Act in filling service gaps.
4. Accurately document service outcomes and demonstrate the effectiveness of treatment, care and prevention strategies.
5. Respond to and advocate for consumer needs.
6. Provide services that are sensitive to the cultural and linguistic needs of specific communities.

## Section III

# HOW WILL WE GET THERE?

## CHAPTER 8: GOALS, OBJECTIVES & ACTION STEPS

In the previous section, we described the ideal Continuum of Care for the Houston area. Here, we present community-defined goals and objectives for transforming our ideal vision into reality.

### CDC & HRSA Goals and Objectives

At the Federal level on the *prevention* side, the CDC recommends that in order to implement a comprehensive HIV prevention program, State, local, and territorial health departments that receive HIV Prevention Cooperative Agreement funds should assure that efforts in their jurisdictions include a compilation of essential components.

### CDC Goals for Prevention

1. HIV prevention community planning;
2. Epidemiologic and behavioral HIV/AIDS surveillance, as well as collection of other health and demographic data relevant to HIV risks, incidence, or prevalence;
3. HIV prevention counseling, testing, referral, and partner counseling and referral services, with strong linkages to medical care, treatment, and other needed services;
4. Health education and risk reduction (HE/RR) activities, including individual-, group-, and community-level interventions;
5. Easy access to diagnosis and treatment of other sexually transmitted diseases;
6. School-based education efforts for youth;
7. Public information programs;
8. Quality assurance and training;
9. Laboratory support;
10. HIV prevention capacity-building activities, including expansion of the public health infrastructure by contracting with non-governmental organizations, especially community-based organizations;
11. Evaluation of major program activities, interventions, and services; and
12. An HIV prevention technical assistance assessment and plan.

On the care side at the Federal level, HRSA has identified the following goals for the effective provision of care to individuals with HIV disease or AIDS and requests that those concerned with HIV/AIDS care focus attention on them.

## **HRSA Goals for Care**

- Goal 1: Improve Access to Health Care
- Goal 2: Improve Health Outcomes
- Goal 3: Improve the Quality of Health Care
- Goal 4: Eliminate Health Disparities
- Goal 5: Improve the Public Health and Health Care Systems
- Goal 6: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Goal 7: Achieve Excellence in Management Practices

## **Houston Area HIV/AIDS Goals, Objectives & Action Steps**

In order to address these mandates, the Comprehensive HIV Services Plan for the Houston Area has adopted the following strategic goals:

**Goal 1:** Identify individuals who know their HIV status but are not in care and develop strategies for informing these individuals of services and enabling their use of HIV related services.

**Goal 2:** Reduce the impact of stigma on access to and retention in care and break down barriers.

**Goal 3:** Provide education and advocacy to encourage HIV+ individuals to get education, stay in treatment, access treatments and be aware of best practices.

**Goal 4:** Improve coordination and collaboration among non-medical service providers.

**Goal 5:** Eliminate disparities in access to and services for historically underserved populations.

**Goal 6:** Coordinate services with HIV prevention programs including outreach and early intervention services.

**Goal 7:** Coordinate services with substance abuse prevention and treatment programs.

**Goal 8:** Prevent youth from becoming HIV+.

**Goal 9:** Continue to develop new programming tactics whereby training, educational materials and clinical measurements continue to support improved HIV epidemiological data outcomes.

**Goal 10:** Provide goals, objectives, timelines and appropriate allocation of pay/funds to services as determined by clients and community.